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RE: OUR CLAIM NO:
INJURED PARTY:
OUR INSURED:
POLICY NUMBER:
DATE OF ACCIDENT:

Dear Provider:

In 1998 New Jersey enacted the Automobile Insurance Cost Reduction Act and as a result there were established obligations which you must satisfy for coverage of medically necessary treatment, diagnostic testing and durable medical equipment arising from injuries sustained in an automobile accident. During the course of your claim, you may be contacted by our PIP vendor, Prizm, LLC as it relates to obligations you have while receiving medical treatment for your injuries and any subsequent bills. This contact may include, but isn't limited to your obligation to attend an Independent Medical Examination. Failure to abide by the following obligations may affect the authorization for medical treatment, diagnostic testing and durable medical equipment.

Prizm, LLC has been selected by NGM Insurance Company to implement their plan as required by the Automobile Insurance Cost Reduction Act. Prizm will review treatment plan requests for Decision Point Review/Precertification, perform Medical Bill Re-pricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services.

The Plan Administrator of this plan is:

Prizm, LLC
523 Fellowship Rd
Suites 275/280
Mt. Laurel, NJ 08054
Phone Number: 1-856-596-5600
Fax Number: 1-856-596-6300
Email Address: Documents@Prizmllc.com

If certain medically necessary services are performed without notifying NGM Insurance Company or Prizm, a penalty/co-payment may be applied. Medical care provided in the first 10 days following the covered loss or any care received during an emergency situation is not subject to Decision Point Review/Precertification. Such treatment (within the first 10 days) may be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary. If Prizm was not provided the prospective notice for it, any identified treatment (as noted in the Plan) administered after the 10-day period will be subject to retrospective review, as well as any applicable penalties.

NGM Insurance Company's Personal injury protection coverage shall provide reimbursement for all me dically necessary expenses for the diagnosis and treatment of injuries sustained from a covered auto mobile accident up to the limits set forth in the policy and in accordance with NJ personal injury regula tions. "Medically necessary" or "medical necessity" means that the medical treatment or diagno stic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:

- The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols consisting of evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals;
- The Care Paths, as applicable;
- The treatment of the injury is not primarily for the convenience of the injured person or provider; and
- Does not include unnecessary testing or treatment. "Standard professional treatment protocols".

As it relates to this Decision Point Review Plan "Business hours" are defined as Monday through Friday, between the hours of 8:00 AM and 5:00 PM, EST, except for federally and/or State Declared Holidays and New Jersey Declared State of Emergencies where travel is prohibited.

As it relates to this Decision Point Review Plan, the following applies when "Days" are referenced:

- "Days" means calendar days unless specifically designated as business days.
- A calendar and business day both end at the time of the close of business hours.
- In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included.
- The last day of a period of time designated as calendar days is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

Response on Decision Point Review and Precertification requests must be communicated to the treating provider no later than three (3) business days after the submitted request. **Example**: A provider submits a proper request on Monday at 6:00 PM, which is one (1) hour after the close of business hours at 5:00 PM. A response is due back to the treating provider no later than Friday at the close of the business hours.

Decisions on pre-service appeals shall be communicated to the provider no later than fourteen (14) days from the date the insurer receives the appeal. **Example**: The insurer receives the appeal by facsimile; transmission dated 3:00 P.M. on Monday, January 2. Day one (1) of the fourteen (14) day period is Tuesday, January 3. The 14th day would be Monday, January 16, however there is a State of Emergency Declared in New Jersey on Monday, January 16th due to inclement weather. The insurer's decision is due no later than Tuesday, January 17, providing the State of Emergency has been lifted.

Decisions on post-service appeals shall be communicated to the provider no later than thirty (30) days from the date the insurer receives the appeal. **Example**: The insurer receives the appeal by facsimile; transmission dated 3:00 P.M. on Tuesday, June 28. Day one (1) of the thirty (30) day period is Wednesday, June 29. The 30th day would be Friday, July 29, as July 4 is a federally declared holiday.

Submission of Treatment Plan Requests for Decision Point Review/Precertification

Please complete the attached "Attending Provider Treatment Plan" form and forward with any applicable medical documentation to Prizm by fax 1-856-596-6300, or mail to 523 Fellowship Road, Suites 275/280, Mt. Laurel, NJ 08054 or email to Documents@Prizmllc.com. This form is available on Prizm's website at Prizmllc.com. Any questions regarding your treatment request can be directed to Prizm at 1-856-596-5600 during regular business hours of Monday through Friday 8:00 a.m. to 5:00 p.m. Eastern Time, except for federally declared holidays and/or state declared holidays and/or New Jersey declared State of Emergencies related to inclement weather where travel is prohibited.

Decision Point Review

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, known as **Care Paths**, for soft tissue injuries, collectively referred to as **Identified Injuries**.

Additionally, guidelines for certain diagnostic tests have been established by the New Jersey Department of Banking and Insurance according to N.J.A.C. 11:3-4. **Decision Points** are intervals within the Care Paths where treatment is evaluated for a decision about the continuation or choice of further treatment the attending physician provides. At Decision Points, the injured party or the health care provider must provide Prizm with information regarding further treatment the health care provider

intends to provide. The Care Paths and accompanying rules are available on the Internet at the Department's website at www.state.nj.us/dobi/pipinfo/aicrapg.htm.

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis:

1. Brain Audio Evoked Potential (BAEP)
2. Brain Evoked Potential (BEP)
3. Computer Assisted Tomograms (CT, CAT Scan)
4. Dynatron/Cybex-Station/Cybex Studies and any range of muscle motion testing
5. Electroencephalogram (EEG)
6. H-Reflex Studies
7. Magnetic Resonance Imaging (MRI)
8. Needle Electromyography (needle EMG)
9. Nerve Conduction Velocity (NCV)
10. Somatosensory Evoked Potential (SSEP)
11. Sonogram/ultrasound
12. Visual Evoked Potential (VEP)
13. Brain Mapping
14. Thermography/Thermograms
15. Videofluoroscopy

Precertification

Pursuant to N.J.A.C. 11:3-4.7, NGM Insurance Company's Precertification Plan requires pre-authorization of certain treatment/diagnostic tests or services. Failure to precertify these services may result in penalties/co-payments even if services are deemed medically necessary and such treatment may be subject to retrospective review. If the injured party does not have an identified injury, you as the treating provider are required to obtain Precertification of treatment, diagnostic tests, services, prescriptions, durable medical equipment or other potentially covered expenses as noted below:

1. Non-emergency inpatient and outpatient hospital care.
2. Non-emergency surgical procedures.
3. Extended care rehabilitation facilities.
4. All outpatient care, including follow up evaluations, for soft tissue/disc injuries of the injured person's neck, back and related structures not included within the diagnoses covered by the Care Paths.
5. All physical therapy, including follow up evaluations by the referring physician, except as provided for identified injuries in accordance with Decision Point Review. The physical therapy must be rendered by a licensed physical therapist pursuant to a referral from a licensed physician, dentist, podiatrist or chiropractor within the scope of the respective practices.
6. All occupational, speech, cognitive, rehabilitation or other restorative therapy or therapeutic or body part manipulation, including follow up evaluations by the referring physician, except as provided for identified injuries in accordance with decision point review.
7. All outpatient psychological/psychiatric treatment/testing or other services.
8. Home Health Care.
9. Non-emergency Dental Restorations.
10. Temporomandibular disorder; any oral facial syndrome.
11. Carpal tunnel syndrome.
12. Infusion therapy.
13. Durable Medical Equipment (including orthotics, prosthetics and associated supplies) with a cost or monthly rental in excess of $100.
14. Non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of $100 or rental in excess of 30 days, including but not limited to:
    a. Vehicles;
    b. Modifications to vehicles;
    c. Durable goods;
    d. Furnishings;
    e. Improvements or modifications to real or personal property;

f. Fixtures;
g. Spa/gym memberships;
h. Recreational activities and trips;
or
i. Leisure activities and trips.

15. Non-emergency medical transportation with a round trip transportation expense in excess of $100.
16. Acupuncture, except as provided for identified injuries in accordance with Decision Point Review, when a referral or diagnosis and pre-evaluation form were received from the referring or diagnosing physician and a signed informed consent has been received.
17. All pain management services, except as provided for identified injuries in accordance with Decision Point Review, including, but not limited to:

    a. Nerve blocks;
    b. Manipulation under anesthesia;
    c. Anesthesia when performed in conjunction with invasive techniques;
    d. Epidural steroid injections;
    e. Radio frequency/rhyzotomy;
    f. Narcotics, when prescribed for more than three months;
    g. Biofeedback;
    h. Implantation of spinal stimulators or spinal pumps; or
    i. Trigger point injections.

18. Current Perception Testing.
19. Computerized Muscle Testing.
20. Nutritional Supplements.
21. All treatment and testing related to balance disorders.
22. Bone Scans.
23. Podiatry.
24. Urine drug testing for prescription management or drug abuse identification.
25. Prescription Drugs costing more than $100
26. All procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPC code.

New Jersey Personal Injury Protection Law prohibits reimbursement for the following tests:

1. Brain mapping, when not done in conjunction with appropriate neurodiagnostic testing;
2. Iridology;
3. Mandibular tracking and stimulation;
4. Reflexology;
5. Spinal diagnostic ultrasound;
6. Surface electromyography (surface EMG);
7. Surrogate arm mentoring; or
8. Any other diagnostic test that is determined to be ineligible for coverage under Personal injury Protection Coverage by New Jersey law or regulation.

Pursuant to N.J.A.C. 13:30-8.22(b), the Personal Injury Protection medical expense coverage shall not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat TMJ/D:

1. Mandibular tracking;
2. Surface EMG;
3. Sonography;
4. Doppler Ultrasound;
5. Needle EMG;
6. Electroencephalogram (EEG);
7. Thermograms/thermographs;
8. Videofluoroscopy;
9. Reflexology; or

10. Any other treatment or test that is determined to be ineligible for coverage under Personal injury Protection Coverage by New Jersey law or regulation.

New Jersey Personal Injury Protection Law prohibits reimbursement for the following treatment:

1. Kinesio Tape;
2. X-ray Digitization; and
3. Any other treatment or test that is determined to be ineligible for coverage under Personal injury Protection Coverage by New Jersey law or regulation.

Decision Point Review/Precertification Process

On behalf of NGM Insurance Company, Prizm will review all treatment plan requests and medical documentation submitted. A decision will be made three business days after the receipt of a completed Attending Provider Treatment Plan form request with supporting medical documentation. If additional information is requested, the decision will be provided within three days of our receipt of the additional information. In the event that NGM Insurance Company or Prizm does not receive sufficient medical infor mation accompanying the request for treatment, diagnostic tests or services, to make a decision, an admi nistrative denial will apply, until the information is received. An administrative denial will also apply to phy sical therapy and acupuncture, if the requirements in the Precertification provision have not been met. If a decision is not made within three business days of receipt of an Attending Provider Treatment Plan form, you, as the treating health care provider, may provide medically necessary treatment until a decision is made.

All treating providers are required to submit all requests on the “Attending Provider Treatment Plan” for Decision Point Review and Precertification treatment requests. A copy of this form can be found on the New Jersey Department of Banking and Insurance (NJDOBI) website www.state.nj.us/dobi/pipinfo/aicrapg.htm or at Prizm’s website Prizmllc.com.

Failure to submit a completed Decision Point Review and Precertification treatment request, including but not limited to a completed “Attending Provider Treatment Plan” and legible clinically supported records, will result in the submitting provider being notified, within three business days of the incomplete submission of what is needed to complete the precertification submission.

Providers who submit Decision Point Review/Precertification are those providers who, in part, physically a nd personally perform evaluations of the injured person’s condition, state the specific treatment and set tr eatment goals. NGM Insurance Company will not accept Decision Point Review/ Precertification requests from the following providers:

- Hospitals
- Radiology Facilities
- Durable Medical Equipment Companies
- Ambulatory Surgery Centers
- Registered bio-analytical laboratories
- Licensed health maintenance organizations
- Transportation Companies
- Suppliers of prescription drugs/Pharmacies

If any of the above restricted providers submits a Decision Point Review/Precertification request, Prizm will respond to them three business days after the request informing them that they are a restricted provider and instruct them that the submission must be made by the referring/treating provider.

All decisions regarding requests for precertification will be transmitted to the provider identified on the Attending Physician Treatment Plan forwarded for consideration. We will not send notification to another business or entity if they faxed an Attending Physician Treatment Plan to Prizm LLC, or requested notification of a decision regarding the request for precertification. We will only send notifications to the provider identified on the Attending Physician Treatment Plan who requested the specified treatment, testing or Durable Medical Equipment.

Decisions that may be communicated to you

Approved: A request for treatment/testing/Durable Medical Equipment is approved by either the Nurse or a Physician Advisor (if forwarded to a Physician Reviewer) or as a result of an Independent Medical Examination.

Denied: A request for treatment/testing/Durable Medical Equipment is denied either by a Physician Advisor or an Independent Medical Examiner.

Modified: A request for treatment/testing/Durable Medical Equipment is modified either by a Physician Advisor or an Independent Medical Examiner.

Administrative Denial: Failure to submit "Attending Provider Treatment Plan" or an incomplete Decision Point Review and Precertification treatment request, including but not limited to an incomplete "Attending Provider Treatment Plan" and legible clinically supported records will result in the submitting provider being notified, within three business days of the incomplete submission of what is needed to complete the precertification submission. Upon receipt of the required additional information, the completed request will be reviewed and a decision will be rendered three business days after the submission.

Retrospective DOS: If the request for treatment/testing/Durable Medical Equipment is for a date of service which has already occurred, a decision of Retrospective date of service will be rendered.

Pended to IME: If based on the Physician Advisor's opinion a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and the most appropriate specialty related to the treating diagnoses) at a location reasonably convenient to the examinee is scheduled within seven calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

Restricted Provider prohibited from submitting Decision Point Review/Precertification: Provider will be instructed that the submission must be made by the referring/treating provider.

Previously Requested: If the requested treatment/testing/Durable Medical Equipment has already been requested by the same provider (DOS and CPT codes) or an ancillary provider (related CPT codes to primary procedure i.e., anesthesia for surgery,) a decision of previously requested will be entered and the decision of the previously requested service will be forwarded to the provider submitting the request.

Please note that the denial of Decision Point Review and Precertification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Voluntary Precertification

We encourage you, as the treating health care provider, to participate in a voluntary Precertification process by submitting a comprehensive treatment plan to Prizm for all services provided. Prizm will utilize nationally accepted criteria to authorize a mutually agreeable course of treatment. In consideration for your participation in this voluntary Precertification process, the bills you submit, consistent with the agreed plan, will not be subject to review or audit as long as they are in accordance with the policy limits, deductibles, and any applicable PIP fee schedule. This process increases the communication between the injured party, provider and Prizm to develop a comprehensive treatment plan and avoid unnecessary interruptions in care.

Independent Medical Examinations

Prizm or NGM Insurance Company may request an Independent Medical Examination. At times, this exam ination may be necessary to reach a decision in response to the treatment plan request by the treating provider. This examination will be scheduled with a provider in the same discipline as the treating provider and the most appropriate specialty related to the treating diagnoses and at a location reasonably

convenient to the injured person. Prizm will schedule the appointment for the examination within seven days of the day of the receipt of the request unless the injured party/designee otherwise agrees to extend the timeframe.

Medically necessary treatment may proceed while the examination is being scheduled and until the Independent Medical Examination results become available. Such treatment may be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary. Upon completion of the Independent Medical Examination, you, as the treating provider, will be notified of the results by fax or mail within three business days after the examination. A copy of the examiner's report is available upon request. If NGM Insurance Company or Prizm fails to respond to the request within three business days of receipt of the necessary information, the treating provider may continue the test, course of treatment, or durable medical equipment until such time as the final determination is communicated to the provider.

Prizm will notify the injured party or designee and the treating provider of the scheduled physical examination and of the consequences for unexcused failure to appear at two or more appointments. The following will constitute an unexcused failure:

1. Failure of the injured party to attend a scheduled IME without proper notice to Prizm.
2. Failure of the injured party to notify Prizm at least two days prior to the IME date.
3. Any reschedule of an unattended IME that exceeds 35 calendar days from the date of the original IME, without permission from NGM Insurance Company.
4. Failure to provide requested medical records, including radiology films, at the time of the IME.
5. If the injured party being examined does not speak English, failure to request or provide an English speaking interpreter for the exam.
6. Failure to provide adequate proof of identification.

If the injured party has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all the providers treating the injured person for the diagnosis (and related diagnoses) contained in the attending physicians treatment plan form. The notification will place the injured party on notice that all treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnoses) contained in the Attending Physician's Treatment Plan form and future treatment, diagnostic testing or durable medical equipment related to the diagnosis (and related diagnoses) will not be reimbursable as a consequence for failure to comply with the plan.

Voluntary Network Services

Prizm has established a network of approved vendors for diagnostic imaging studies for all MRIs and CAT Scans, durable medical equipment with a cost or monthly rental over $100, prescription drugs and all electro- diagnostic testing, listed in N.J.A.C 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG, H- Reflex and NCV Studies by the treating provider). If the injured party utilizes one of the pre-approved networks, the 30% co- payment will be waived. If any of the electro-diagnostic tests listed in N.J.A.C. 11:3-4.5(b) are performed by the treating provider in conjunction with the needle EMG, H-Reflex and NCV Studies, the 30% co-payment will not apply. In cases of prescriptions, the $10 co-pay of NGM Insurance Company will be waived if obtained from one of the pre-approved networks.

When one of the services listed below is authorized through NGM Insurance Company's Decision Point Re view/Precertification process, detailed information about voluntary network providers will be supplied to the injured party or requesting provider as noted below. Those individuals who choose not to utilize the networks will be assessed an additional co-payment not to exceed 30% of the eligible charge. That co-payment will be the responsibility of the injured party.

Once an MRI and/or CAT Scan Diagnostic test that is subject to pre-approval through Decision Point Review/Precertification is authorized, a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact the injured party and schedule the test at a time and place convenient to them.

Durable Medical Equipment with a cost or monthly rental over $100 is subject to Decision Point Review/Precertification process. Once the Durable Medical Equipment is authorized a representative of

Prizm will contact the vendor and forward the information to them for scheduling purposes. The equipment will be shipped to the injured party from the vendor, 24 hours after the request is received.

When the injured party needs prescription drugs, a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of participating pharmacies will be mailed to the injured party once the need for a prescription has been identified. Requests for narcotics which are prescribed for more than three months are subject to Decision Point Review/Precertification.

Once an Electro-diagnostic Test subject to pre-approval through Decision Point Review/Precertification is authorized, a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will then contact the injured party and schedule the test at a time and place convenient to them. When Electro-diagnostic tests are performed by the treating provider, in conjunction with a needle EMG H-Reflex, NCV Studies, the 30% co-payment will not apply.

Penalty Notification

Failure to submit requests for Decision Point Review or Precertification where required (identified treatment after 10 days as noted in the Plan) or failure to submit clinically supported findings that support the treatment, diagnostic testing, or durable medical goods requested will result in a co-payment penalty of 50%. This co- payment is in addition to any co-payment stated in the insured's policy.

If the injured party does not use a network provider/facility to obtain those services, tests or equipment listed in the voluntary network services, payment for those services will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Treatment that is not medically necessary is not reimbursable under the terms of the policy.

Any reduction shall be applied prior to any other deductible or co-payment requirement.

Assignment of Benefits

If the provider accepts an assignment of benefits from the injured party, they are required to hold harmless the injured party, named insured and insurance carrier from any reduction in benefits caused by a failure on their part to comply with the Decision Point Review/Precertification Plan. If the provider accepts an assignment of benefits, they must:

1. Agree to follow all of the requirements of our Decision Point Review Plan for making Decision Point Review and Precertification requests; and
2. Hold the injured party, named insured and insurance carrier harmless for penalty co-payments imposed by us based on their failure to follow the requirements of our Decision Point Review Plan.

Please note that any provider that has accepted an assignment of benefits must comply with and complete the Appeals Process as noted below prior to initiating arbitration or litigation. Completing the appeals process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

Failure on the part of the provider to comply with the above will render any assignment of benefits null and void. Should the assignee choose to retain an attorney to handle the appeals process, it would be at their own expense.

Internal Appeal Process

The Internal Appeal Process must be followed before filing arbitration or litigation. All appeals must be submitted to:

Prizm, LLC
523 Fellowship Rd
Suites 275/280
Mt. Laurel, NJ 08054
Phone Number: 1-856-596-5600
Fax Number: 1-856-596-6300
Email Address: Documents@Prizmllc.com

Pre-service and Post Service Appeal forms can be found on Prizm's website at Prizmllc.com or New Jersey Department of Banking and Insurance's website at www.state.nj.us/dobi/pipinfo/aicrapg.htm.

In accordance with NJAC 11:3-4.7B, NGM Insurance Company's Appeal Process is as follows:

Pre-service Appeals

1. If a request for medical services is denied or modified by a Physician Advisor Review or an IME, the treating provider must request a reconsideration of the physician's recommendation prior to the performance or issuance of the requested service. The request must be made in writing within 30 days of the receipt of the recommendation to deny the DPR or Pre-Certification request. The request must include a properly completed Pre-Service Appeal Form (as defined in 2. below) in accordance with NJAC 11:3-4.7(d), the original Attending Provider Treatment Plan (APTP) being appealed, the APTP Decision/Response document being appealed, an appeal rationale narrative, the appeal physician's signature and reasons for reconsideration along with any additional supporting documentation.

2. If the required information is not submitted at the time the pre-service appeal is received, the appeal will be denied administratively and will not be addressed. Provider will be notified of the insufficiencies contained in their appeal submission and will be given the opportunity to resubmit correctly.

3. A properly completed Pre-Service Appeal Form must include:

    a. Date Appeal Submitted (box 1)
    b. Receipt Date of Adverse Decision (box 2)
    c. All Claim Information (boxes 3-5)
    d. All Patient Information (boxes 6-13)
    e. Provider/Facility Information (boxes 14-25)
    f. Required Documents attached
        i. Original APTP Form
        ii. APTP Decision/Response document
        iii. Appeal rationale narrative
        iv. Additional new supporting records
    g. Pre-service Appeal Issues (boxes 30-34 as appropriate)
    h. Only one APTP should be submitted per Pre-Service Appeal Form. If multiple APTP's require a pre- service appeal, a separate Pre-Service Appeal Form should be submitted for each unique APTP.
    i. Signature of Provider (box 35)

4. The properly completed Pre-Service Appeal Form and required attached documents should be submitted to Prizm via fax at 1-856-596-6300, electronically at Documents@prizmllc.com or mailed to P.O. Box 5480, Mt. Laurel, NJ 08054.

5. It may be determined that an Independent Medical Examination is necessary. If this is the case, the appointment must be scheduled within seven calendar days of receipt of the appeal request unless the injured party agrees to extend the time period. The examination must be held in a

location convenient to the injured party with a health care provider of the same discipline and the most appropriate specialty related to the treating diagnoses as the treating provider.

6. Prizm's response to the appeal will be communicated to the treating provider in writing by fax or mail 14 days after the receipt of the request.

Post service Appeals

1. If the appeal is for any issue, other than treatment denials or modifications done by a Physical Advisor Review or an IME, subsequent to the performance or issuance of the services, a treating provider must request a reconsideration through Prizm. This request must be made within 90 days of receipt of the explanation of benefits and at least 45 days prior to initiating alternate dispute resolution pursuant to NJAC 11:3-5. The request must include a properly completed Post Service Appeal Form in accordance with NJAC 11:3-4.7(d), (as defined in 2. below) the original bill (HCFA/UB), the Explanation of Benefits/Payment, the signature of the treating provider and reason(s) for reconsideration along with any additional supporting documentation.

2. If the required information is not submitted at the time the post-service appeal is received, the appeal will be denied administratively and will not be addressed. Provider will be notified of the insufficiencies contained in their appeal submission and will be given the opportunity to resubmit correctly.

3. A properly completed Post-Service Appeal Form must include:

    a. Date Appeal Submitted (box 1)
    b. Receipt Date of Adverse Decision (box 2)
    c. All Claim Information (boxes 3-5)
    d. All Patient Information (boxes 6-13)
    e. Provider/Facility Information (boxes 14-25)
    f. Required Documents attached
        i. Original Bill (HCFA/UB)
        ii. Explanation of Benefit/Payment
        iii. Appeal rationale narrative
    g. Post-service Appeal Issues (boxes 30-38 as appropriate)
    h. Only one EOB ID should be submitted per Post-Service Appeal Form. If multiple EOB's require a post- service appeal, a separate Post-Service Appeal Form should be submitted for each unique EOB ID.
    i. Signature of Provider (box 39)

4. The properly completed Post-Service Appeal Form and required attached documents should be submitted to Prizm via fax at 1-856-596-6300, electronically at Documents@prizmllc.com or mailed to P.O. Box 5480, Mt. Laurel, NJ 08054.

5. Prizm's written response to this appeal will be communicated to the requesting provider by fax or mail within 30 days after the receipt of the appeal form and any supporting documentation.

One Level Appeal Requirement

Each issue shall require one internal appeal submission prior to making a request for alternate dispute resolution. A request that has been denied administratively does not constitute an appeal. A pre-service appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than a post-service appeal of what the insurer should reimburse the provider for that same service. If a provider submits a pre-service appeal or the modification or denial of treatment by a Physician Advisor Review or an IME and subsequently performs the services and receives an Explanation of Benefits denial on the basis of the same PAR or IME, the one level appeal requirement has been met and the provider is no longer able to appeal the same issue as a post service appeal.

Should the treating provider choose to retain an attorney to handle the Appeals Process, they do so at their own expense. No counsel fees or any other costs incurred during the Appeal process will be

compensated regardless of whether the dispute is resolved on appeal or litigated.

Payments/ Reimbursement

NGM Insurance Company will reimburse all eligible medically necessary services in accordance with the most current New Jersey PIP Regulations and Fee Schedule relating to the date of service. When a provider bills CPT codes for medically necessary services that are not noted in a fee schedule, NGM Insurance Company will reimburse the service referencing fees for similar services on the fee schedule or use the most current version of FAIR Health Data Base, consistent with the date of service, 75th percentile and with the providers' zip code, as proof of a usual, customary and reasonable fee, whichever is less.

For Pharmacy bills which aren't noted in a fee schedule, NGM Insurance Company will use the most current version of the RedBook with the geozip noted on the provider's address noted on the Explanation of Benefits.

If the provider participates in an applicable PPO network, services may be reimbursed in accordance with the amount permitted under the PPO agreement.

NGM Insurance Company has no obligation to reimburse for specific CPT/HCPC codes if they were appr oved (certified) in a Decision Point Review/Precertification request as it relates to applying payment meth odology in the NJ PIP regulations, including but not limited to the NCCI edits. If the NCCI edits prohibit reimbursement for the codes that were billed, such codes will not be reimbursed. The New Jersey Department of Banking and Insurance has adopted the NCCI edits to prevent duplication of services and unbundling of codes and the NCCI edits are part of NGM Insurance Company's obligation to only reimburse for medically necessary treatment. You may obtain the entire current NCCI edits from the following website: cms.gov/NationalCorrectCodInitEd/.

Dispute Resolution Process

If there is any dispute that is not resolved at the Internal Appeal Process, it may be submitted through the Personal Injury Protection Dispute Process (N.J.A.C 11:3-5). This can be initiated by contacting Forthright at 1 (732) 271-6100 or at 1 (888) 881-6231. Information is also available on Forthright's website at nj-no-fault.com. NGM Insurance Company retains the right to file a motion to remove any Sup erior Court action to the Personal Injury Dispute Resolution Process pursuant to N.J.S.A. 39:6A-5.1. Unl ess emergent relief is sought, failure to utilize the Internal Appeal Process prior to filing arbitration or litig ation will invalidate an assignment of benefits.

The staff at Prizm remains available to you and your patient in order to assist with the Decision Point Review/Precertification Process.

Sincerely,

NGM Insurance Company